Questions and Answers
Issued on: July 26, 2006

Request for Proposal RFP-MQD-2007-002
QUEST Managed Care Plans to Cover Medicaid and Other Eligible Individuals Who Are Not Aged, Blind, or Disabled

# Assigned	Section	Page #	Para.	Question	Response
1	10.100	1	1	This paragraph indicates DHS "reserves the right to add new eligible groups and to negotiate new or different rates to include coverage of these new groups." Will the Aged, Blind and Disabled and Long Term Care populations and the Medicaid Dental Program be considered a "new eligible group"? If so, will the health plans be required to accept this new eligible group?	While these are "new eligible groups" this contract will not include these groups. .
2	10.100	1	2	When will the separate RFP for adult behavioral health services be issued?	There will not be a RFP; the State will be responsible for care.
3	10.100	1	4	What is considered a significant change to the RFP that would result in DHS providing additional time to submit RFP proposals?	A significant change is one that impacts the QUEST program and this RFP such that the DHS believes offerors may benefit from additional time to submit proposals.
4	20.100	5	Timeline	DHS' written responses to the technical proposal questions is scheduled for release on July 24. Three weeks later, the bid proposals are due (8/11). DHS' responses to many of the questions posed will help Plans formulate their answers to the RFP questions. Could you please consider releasing the answers to the written questions earlier than July 24?	No, the State will not release the answers prior to July 24. See #1 and #2 of Amendment #8.
5	20.100	5	Timeline	Will there be a bidders' meeting to discuss/clarify the DHS written responses to the questions submitted by potential bidders scheduled for release on July 24th?	No, there will not be a bidders' meeting.
6	20.100	5	Timeline	If the commencement of services to members is February 1, 2007, will the HEDIS and EQRO review periods as well as other contractual reporting requirements be adapted to reflect only those services/requirements that were within the scope of this RFP?	Yes.

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7	20.100	5	1	If written responses to the questions are delayed, will the RFP proposal due date be delayed by the same amount of days?	Yes. See #1 of Amendment #8.
8	20.100	5	1	Will health plans have an opportunity to ask follow-up questions for further clarification if written responses to questions are not clear? If yes, how will this affect the RFP timeline?	No, health plans will not have the opportunity to ask follow-up questions.
9	20.100	5	Timeline	Will current QUEST Plans be operating under two contracts from September 12, 2006 through December 31, 2006? If so, how do we apply benefits under two contracts? What will be the respective responsibilities of the State and the Health Plan during this period? Can DHS issue responses to written questions to the Technical proposal earlier than July 24, 2006? This date does not allow sufficient time for the plans to make necessary revisions to their proposals.	Yes, current QUEST Plans will be operating under 2 contracts. Benefits will be provided under the existing contract through January 31, 2007. Benefits under the new contract procured as a result of this RFP (RFP-MQD-2007-002) will begin on February 1, 2007. During the months previous to service provision under the contract signed as a result of this RFP the health plans will be undergoing readiness reviews to be conducted by the State. See response to Question #4 regarding issuing responses prior to July 24, 2006.
10	20.600	8	1	For multiple/jointly submitted RFPs as described in section 10.400, would all entities involved in that RFP be required to obtain a Certificate of Good Standing from the Dept. of Commerce or only the prime offeror?	Only the prime offeror will be required to submit a Certificate of Good Standing.
11	20.800	10	1 & Bullet 10	Will DHS notify the health plans when the information on the development of the capitated rate ranges will be available in the documentation library?	Yes. See Amendment #3 uploaded on 7/10/06; Age Gender Factors uploaded on 7/10/06; Data Book Cap Rates Bid Forms uploaded on 7/10/06; Data Book uploaded on 7/10/07.

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12	20.920	11	2	Will all potential bidders be included in any and all discussions DHS has to promote understanding of the purchasing agency's requirements?	The DHS will comply with all procurement laws as it relates to contact with potential offerors.
13	21.600	13	2nd paragraph	Please clarify if a certified statement regarding independent price determination is required. Section 21.600 says it should be included in the proposal. It's also in Section 100.300 (pg 339) as a "mandatory requirement". However, it is not included in Section 80.	See #49 of Amendment #9.
14	21.800	15	1	"DHS also reserves the right to waive minor irregularities in the proposal." What would be an example of a minor irregularity? Is there a list of items that would be considered as "irregularities"?	The DHS will make determinations of minor irregularities and will not provide any examples.
15	22.100	17	Bullet 2	"An offeror's lack of responsibility and cooperation as shown by past work or services" are reasons for disqualification- what constitutes "lack of responsibility and cooperation" – how is this evaluated, or can you provide examples?	This will be evaluated by the State under its procurement authority
16	22.500	20	2	Does DHS plan to have a public opening of the business proposals as they have done in the past?	No.
17	30.200	38	2	The definition of Medical Necessity used here differs from §432E-1.4 (see Attachment 1). Section 70.100, page 270, paragraph 4 states that in the event of a conflict between the language of the contract, and applicable statues and regulations, the latter shall prevail. Does this mean the definition described in §432E-1.4 should be the definition used under this contract? If no, please explain why not.	The definition of medical necessity in this section of the RFP governs the provision of services under the contract. The definition in §432E-1-4 does not apply to the Medicaid program. HRS 346-14(1) & (7) provide authorization for DHS to establish standards governing benefits for the Medicaid program.

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18	30.320	48	2nd to last paragraph	"Adults enrolled in QUEST-Net with incomes exceeding 100%....." A portion of the sentence after the reference to "100%" appears to be missing. Are you referring to 100% of the FPL?	Yes. See #3 of Amendment #9.
19	30.340	49	2nd paragraph	It states that individuals entering the QUEST program from an inpatient facility located in the continental US or US Territories shall not be enrolled in a health plan until they return to the State of Hawaii. Does this also apply to newborns?	If the mother of the newborn is a QUEST recipient at the time of the birth and was sent to the mainland by a health plan for medical care or was on the mainland for some other reason and goes into labor then the health plan is responsible for the newborn from birth.
20	30.510	54	Last	To ensure a smooth transition into a new health plan during positive enrollment for existing members, all prior authorizations approved by the old plan shall be honored for at least 45 days or until the member's new PCP has assessed the member. Some members may not access PCP services for an extended period of time and may not have valid contact information to allow the new plan to establish contact with the member. Could you please clarify what the minimum requirement is? Is it whichever option occurs sooner? If the member is receiving the preapproved services from a specialist, can the specialist perform the assessment in lieu of the PCP?	The minimum requirement is for whichever occurs sooner. The plan may allow a specialist who is acting as a PCP to assess the needs of its members; other specialists (including those who are providing the services if the specialist is not acting as a PCP) shall not be permitted to provide the assessment.

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# Assigned	Section	Page #	Para.	Question	Response
21	30.510	54	Last	The RFP states that during the transition into a new health plan, a new HP must honor all prior authorizations by the member's old HP for at least 45 days or until the member's medical needs have been assessed by the new PCP. Not all plans use the same Clinical Criteria. Our quality program mandates conformance with inter-rater reliability standards/tools, and the EQRO has reviewed these processes in the past. Can we exclude any authorizations that we need to "approve" and honor from another health plan from review by the EQRO as far as whether we are following our clinical criteria consistently?	The health plan should contact members with services prior authorized to schedule an appointment with their assigned PCP to do the assessment. This will solve any issues with clinical criteria exclusive to the Health Plan. Coordination during the transition will be key in ensuring continuity of care.
22	30.510	54	3	How will the "new" health plan know what prior authorizations were approved by the member's "old" health plan while still complying with HIPAA? If it will be through a member release, then can this section be amended to add with a signed release from the member?	HIPAA Privacy Rules permits the exchange of member information between the health plans and MedQUEST as the State Medicaid agency without individual member authorizations. MedQUEST will enter into confidentiality agreements with existing health plans to transfer the prior authorization data. The State will acquire the prior authorizations for service from the existing health plans issued the last 30 days of the contract pursuant to Section xxx of existing MedQUEST contract. MedQUEST and the health plans will work collaboratively to ensure a seamless transition to protect continuity of care.
23	30.510	54	3rd paragraph	Does the timeframe in the sentence ("…for at least forty-five (45) calendar days, or until the member's medical needs have been assessed by the PCP assigned to the member…") mean *until the member's medical needs have been assessed by the new PCP, **but** not less than 45 calendar days?*	Which ever event occurs first. If the member presents and or schedules an appointment to access the prior authorized service the health plan must honor the PA and have the individual schedule an appointment with their PCP for an assessment.

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24	30.520	55	Newborn Enrollment	A newborn will be enrolled into the health plan of the mother retroactive to the date of birth. The newborn auto-assignment will be effective for 30 days following birth. Services for newborn care submitted to the health plan for payment need to be recognized and processed and the provider not kept waiting. If we do not receive an enrollment within 90 days from date of birth, can the HP deny claims and notify providers to pursue payment from another source for newborn services provided during the initial 30 day period? If enrollment into the HP is never received, is the HP obligated to pay for services received by the newborn for the initial 30 day period? (If the plan does not receive enrollment, we do not receive the associated capitation from the State).	The health plan may not deny claims and notify providers to pursue payment from another source. If enrollment is not received within 90 days from date of birth the health plan shall work with the State to resolve the issue; the health plan is obligated to pay for services received by the newborn for the initial 30 day period..
25	30.520	55	1	Although the first 30 days following a newborn birth will be covered by the mother's health plan, can a health plan wait to receive eligibility from DHS before covering services? If no, how can a health plan recover services paid if enrollment from DHS is not received?	No, if enrollment is not received the health plan shall work with the State to resolve the issue.
26	30.530	55	3rd paragraph	This states that children in foster care will be disenrolled at the end of the month in which the request was made and enrollment on the first day of the next month. Will mid-month disenrollment & enrollments (which currently may be initiated by CWS) no longer be allowed?	No mid-month disenrollment/enrollments will be recognized.

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# Assigned	Section	Page #	Para.	Question	Response
27	30.550	56	1st paragraph	How will DHS educate PCPs about how to assist members in changing health plans during the 90-day grace period?	MQD has a provider hotline in our Enrollment Call Center. Providers will be able to call the Enrollment Call Center during the positive enrollment period as well as during the 90-day grace period if they have questions regarding enrollment changes for their patients. In addition, MedQUEST will also share eligibility worker information to help PCPs refer enrollees to assistance.
28	30.550	56	90-Day Grace Period	Members will be allowed to change health plans during the 90 day grace period. Is there a limit on the number of times a member can request a plan change during this time frame?	No.
29	30.550	56	3	Will members who are determined eligible during the 90 grace period also have an opportunity to change health plans without cause through May 2, 2007?	All members have a 90-day grace period upon initial enrollment into a health plan and can change plans without cause during this period. May 2, 2007 only relates to existing members not newly determined eligible members.
30	30.550	56	Entire section	Does this section pertain only to existing members during the positive enrollment period?	No.

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31	30.550	56	1st paragraph	Please confirm that the grace period is only for the first ninety (90) days (2/1/07-5/2/07). The DHS Director's memo to the Legislature (dated 4/26/06) states that "If you missed the opportunity to choose a health plan during these 150 days, don't worry. If you go by mistake ***at any time*** to see your doctor but that doctor does not participate in your new health plan, you will still receive services from that doctor at that visit. You can also switch back to your old health plan at that time if you want." Is there a limit to the number of times an existing member can change plans during the ninety (90) day grace period? How is DHS planning to educate PCPs on the ninety (90) day grace period?	The 90-day grace period is for all existing members upon initial enrollment into a health plan and is from February 1 through May 2, 2007. New members will be allowed to change their plan during the 90-day grace period (February 1 through May 2, 2007). Beyond the 90-day grace period a member may disenroll from a health plan for reasons listed in Section 30.600. There is no limit to the number of times a member can change plans during the 90-day grace period. MQD has a provider hotline in place that will be available to providers to help provide information on enrollment changes. The request to change plans must be requested by the recipient and cannot be initiated by a provider. In addition we will work with Health Plans during the outreach and pre-implementation period to educate and develop a streamlined process.
32	30.550	56	4th paragraph	Member's whose PCP is not in the network of the plan in which the member is enrolled is now an allowable reason for the plan change. Will this change process be administered by DHS?	Yes, in conjunction with the Health Plans.
33	30.560	57	4	If the first annual plan change period will be in September 2007, when will the changes be made effective?	November 1, 2007.

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34	30.570	58	4	When implementing enrollment caps, will QUEST-Net and QUEST-ACE adult members be included in the enrollment count? If yes, will DHS consider lifting the cap if a capped health plan has a disproportionately large number of QUEST-Net and QUEST-ACE adult members?	Yes, at the present time there is no intention to lift the caps. However, DHS has reserved the right in the contract to lift the cap if circumstances warrant.
35	30.570	59	2, #2	Newly determined eligibles that have PCPs that are exclusive to a capped plan will be allowed to enroll with that plan. What process will be followed for the member to identity their PCP to MQD staff so that the enrollment into a capped plan can be achieved?	Health Plans will be required to share information on PCPs who are exclusive to a health plan with MQD. In addition, outreach activity will be conducted with this particular population to facilitate enrollment. The plans will need to submit the plan to plan change form to MQD's Enrollment Call Center with the reason for the request for plan change. If the PCP is on the exclusive list for the particular plan the Enrollment Call Center will allow the enrollment into the capped plan.
36	30.570	59	1	Will DHS implement enrollment caps during the positive enrollment period? Will DHS implement enrollment caps during the 90 day grace period?	Yes to both questions.
37	30.570	59	2	Three exceptions are noted for the enrollment caps by island policy. Will DHS permit a health plan to cap their island enrollment at any time?	No, a health plan will not be allowed to cap their island enrollment.
38	30.570	59	2	How will DHS or "capped" health plans know what providers are exclusive to a health plan?	See answer to question 35.

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39	30.570	60	2	This section states that a review of each health plan's enrollment will occur in September of each year after completion of the annual plan change period to determine if caps should be implemented. Is the initial "Positive Enrollment" period the same as the annual plan change period?	No.
40	30.570	59-60	Member Enrollment Caps	Will the member enrollment cap be imposed/enforced during the open enrollment in Nov/Dec '06 or during the 90 day grace period of the initial year of this contract? If yes, could you please describe the process by which the enrollment cap will be implemented?	Yes to both questions. The capping process will be shared with Health Plans awarded contracts.
41	30.580	60	1	If a member is in a long term care unit within an acute care facility and is disenrolled from the plan and transferred to the Medicaid FFS program, does the plan's responsibility end?	When a member changes health plans or is disenrolled from a health plan and transferred to the Medicaid FFS program, the health plan is financially responsible for all costs through discharge unless the individual has been in an acute wait listed nursing facility bed for 60 days or more.
42	30.580	60-61	Hospitalizations During Enrollment Changes	Currently, Plans are financially responsible for an inpatient stay through discharge or a level of care (LOC) drop to SNF (whichever occurs first) when a member who was hospitalized while under the plan gets disenrolled while still an inpatient. The new RFP eliminates the LOC drop and makes Plans responsible for the member until discharge which means Plans will be responsible for inpatient coverage of individuals for potentially a longer period of time. How will this change in requirement in the new RFP be factored into the proposed capitation rate and will the bidders be able to see and discuss the assumptions with the actuaries?	See response to question 41. This section reflects current policy and will not impact capitation rates.

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43	30.580 30.620	60 66	3rd paragraph	Please clarify rules regarding financial responsibility for hospitalizations during enrollment changes. Section 30.580 states that the plan is responsible through discharge regardless of level of care change. Section 30.620 states that the plan is responsible for up to sixty (60) days if wait listed.	See response to question 41.
44	30.600	63	1, 2nd sentence 4th bullet	RFP states: "The DHS will process all disenrollment requests submitted in writing by the member or his or her representative." One of the appropriate reasons given is member's PCP is not in the health plan's provider network and is in the provider network of a different health plan. Under the current contract, the requests come to the current health plan, and the current plan and receiving plan communicate with each other and have to agree to the plan change request and then forward the information to MQD staff. Does this mean under the current contract that he plans can direct the member(s) to send their requests directly to MQD for processing, without either the current plan or receiving plan being involved?	No, it does not mean this; nothing in the RFP affects the current contract.
45	30.600	63	2 Bullet 4	Does this terminate the current plan to plan change process agreed upon by the current QUEST health plans and Med-QUEST? If yes, will DHS contact the PCP to confirm the member is an established patient and he/she is willing to accept the member?	No, it does not terminate the current plan to plan change process.
46	30.770	72	2	If CAMHD will provide inpatient psychiatric and outpatient behavioral health services, are the health plans responsible for both inpatient and outpatient behavioral health drugs?	The Health Plan remains responsible for providing and paying for physical health services. CAMHD is responsible for behavioral health services including outpatient behavioral health drugs while in the SEBD program.

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# Assigned	Section	Page #	Para.	Question	Response
47	30.780	72	1, 3rd sentence	Individuals that are determined to be disabled will be disenrolled from the health plan. Will MQD accept responsibility for services received by ADRC-approved plan members if the disenrollment is delayed beyond the timeframe noted in this section?	Yes, unless it is in regards to inpatient stay.
48	30.780	72	1	For the ADRC process, can MQD provide a standard timeline associated with the MQD ADRC review process? Ideally, the standard timeline will provide an indication of how long plans may expect the MQD review process will take from the receipt date of all information needed to make a determination to the date of the disability determination.	See #5 of amendment #9 for the maximum amount of time the ADRC review process will take. There is no "standard timeline.".
49	30.810	75	1	Upon completion of reviews by DHS or its designee, is there a specific timeframe health plans can expect a report of its findings?	No. However, MedQUEST will provide the report of its finding when finalized.
50	30.820	77	Bullet 1	In addition to each health plan receiving plan-specific raw data by island, will the health plans also receive a plan-specific CAHPS Survey report and a plan-specific Provider Satisfaction Survey report?	We will consider providing plan specific Provider Satisfaction Survey results.
51	30.900	78	1	QUEST policy memorandums clarify existing requirements or notify plans of changes in policy. The RFP states that QUEST memorandums are available in the Bidder's library. Except for past memorandums specifically referenced within the RFP, are other past memorandums applicable to this contract?	Yes.
52	30.900	78	1st	Are Quest Policy Memorandums distributed by MQD through the mail or are they made available on the State's website?	MedQUEST will mail all QUEST Policy Memorandums issued after contract award to Health Plans for execution pursuant to Section 70.100.

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53	31.100	79	1	The DHS will conduct a readiness review of the health plan that will include, at minimum, one (1) on-site review. If the health plan is a returning health plan, will this be waived due to annual EQRO audits that have been taking place? In addition, could you please elaborate on the degree of extensiveness and intensiveness the DHS will be requiring of the readiness review and the qualifications of the personnel who will be performing the review.	No. The Readiness Review will address all contractual aspects to determine if a Health Plan is prepared to deliver services to the QUEST population and to do so under the terms and conditions of the contract. Multi-disciplined teams will be established to handle the Readiness Review.
54	31.100	79	1	Will existing health plans be subject to readiness reviews described in this section and throughout this RFP since these standards are reviewed on an annual basis by the External Quality Review Organization?	Yes.
55	31.100	79	1st paragraph	Will the 2006 EQRO review be used to meet some of the requirements of the Readiness Review?	No.
56	31.100	79	3rd paragraph	How much time will Plans have to address areas requiring corrective action?	The timeline for required corrective action will be dependent on the identified issue requiring corrective action. However, all corrective action on items identified will need to be complete prior to February 1, 2007.
57	31.210	81	2	"MQD requires that health plan install the DHS approved VPN software..." Could you please confirm that you are referring to the VPN that all current plans have already installed and are using to transfer member and other information to and from MQD?	Yes, it is the VPN software being utilized by existing health plans.
58	40.210	85	2nd paragraph	When terminating a contract, are plans expected to notify DHS before notifying the provider?	Yes, if the "individuals or providers represent five percent (5%) or more of the total providers in that specialty or if it is a hospital."

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59	40.210	89	Last paragraph	"Health plan shall require all providers have a unique physician identifier. Effective May 23, 2007, providers must have a NPI. Can 'requirement' be enforced by denial of claims without NPI? Can this denial be done for paper and electronic claims?	Yes to both he health plans are required to follow the federal requirements relating to the NPI.
60	40.210	90	1, 4th sentence	The health plan shall report provider application denials or terminations of individuals on the exclusions list to the DHS. Please clarify if this is a different report from the Provider Suspension and/or Termination Report that is currently submitted to MQD. If this is a different report, does MQD have a specific format or set of data elements that it would require for this report? Would the report be put on a reporting schedule or submitted as application denials and/or termination occur?	Yes, this is a different report. See # 6 of Amendment #9.
61	40.210	90	1, 5th sentence	Any criminal conviction information provided by the provider to the health plan shall be shared with the DHS. Are there legal privacy restrictions that would disallow the sharing of certain types of data regarding certain types of convictions? Does MQD have a specific format or set of data elements that it would require for this report? Would the report be put on a reporting schedule or only submitted to MQD as information is received? (In effect, the Plan would only report if it receives criminal conviction information from a provider).	This is a federal requirement that requires notification to OIG of any disclosures made regarding the identity of any person who has been convicted of a criminal offense related go persons involved in a program under Medicare, Medicaid, or Title XX. There are no legal privacy restrictions that would disallow the sharing of certain types of data on criminal convictions which are a matter of public record. MQD may develop a specific format for this report. The report shall be submitted to MQD as information is received.

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62	40.220	91	3rd paragraph	This section implies that the plan can pay non-contracted providers whatever the plan chooses and the provider has to accept. Is there a state or federal law that supports this that the plans can cite?	This section does not imply that the plan can pay non-contracted providers whatever the plan chooses. This section requires that the health plan meet provider availability requirements when the service is not available in-network and that members can not be "balanced billed."
63	40.260	96	3rd paragraph	If the Health Plan chooses not to use out-of-network providers, will the Plan Change be handled by MQD? Current plan to plan changes require continuity of care.	See response to Question #44.
64	40.295	105	Bullet 3	Must provider contracts be amended to include explicit language requiring providers to comply with HIPAA provisions if the contracts 1) already include a clause requiring providers to comply with all state and federal laws and regulations; and 2) the providers are required to comply with HIPAA provisions and other state and federal laws to maintain the confidentiality of member's information and records?	Yes, provider contracts do need to be amended.
65	40.295	107	Bullet 3	Are health plans responsible for payments to providers if eligibility for the newborn is not received from Med-QUEST? If no, can this statement be revised?	Yes, they are responsible for payments to providers.
66	40.295	108	2	RFP states: "The health plan shall submit to the DHS all finalized and executed contracts thirty (30) days after the date of contract award." Are returning plans, with previously established networks that have been reported to MQD exempt from the requirement to submit copies of the contracts?	No, returning plans are not exempt from this requirement.
67	40.295	108	bullets	Please clarify the timeframe for plans to submit contracts not previously submitted.	See #7 of Amendment #9.

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68	40.300	108	Covered Benefits & Services	What are the utilization and unit cost assumptions for the benefit enhancements required under the new RFP? Have all the new/added requirements been factored into the proposed capitation rate by the actuaries, how have they been factored into the proposed capitation rate and will the bidders be able to see the entire list of new requirements and discuss the assumptions with the actuaries?	An explanation of the utilization and unit cost assumptions have been included in the Data Book. In addition, health plans were invited to and participated in a teleconference call with access to a computer connected to the internet to view documents and the presentation by the MQD contracted actuary..
69	40.300	108	4th paragraph	Plans will furnish services not less in amount, duration, and scope than services provided in the Medicaid fee-for-service program. May they also impose limits like those in the Medicaid fee-for-service program (e.g., for speech therapy services) except where otherwise specified?	Utilization limits need to be based on individual determination of medical need.
70	40.305	111	1st solid bullet, sub-bullet	Please provide a definition, scope and the minimum expectations for "Medication management and patient counseling"?	There is no one definition, scope or minimum expectation for medication management and patient counseling. Each plan shall have utilization management methods and quality review components that ensure that all members receive the appropriate and medically necessary medication management and patient counseling services.
71	40.305	112	1st solid bullet	May speech therapy be limited to services for "patients with speech, hearing, or language disorders who are expected to improve in a reasonable period of time with therapy", as specified for the Medicaid fee-for-service program at HAR 17-1737-77?	Utilization limits and service limits need to be based on individual determination of medical need.
72	40.305	113	last bullet	For adolescents, the Plan is responsible to cover residential therapy/treatment but not room/board? Please clarify.	The health plan is responsible for the treatment/therapy costs while at the facility. Room and board at the Special Treatment Facilities is not covered by Medicaid.

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73	40.315	116	1	Regarding services for QUEST-Net and QUEST-ACE members, the RFP states: "The health plan shall make an effort to notify the member prior to the health service being provided that it is not a covered benefit or that they will be exceeding the coverage limit." The only time we would know that a service is about to be rendered is if it is a service that requires prior authorization, and we would deny for benefit limits exceeded. We would not know about most other services to be provided to QUEST-Net or QUEST-ACE members in advance. We provide a detailed description of the benefits/limits in the new member packet and member handbook. Would MQD consider this sufficient to meet this requirement?	No, providing a detailed description of the benefits/limits in the new member packet and member handbook is not sufficient to fully satisfy the requirement. For example, if a member consistently seeks services beyond the service limits or services which are not covered and is billed for those services the health plan should help educate the member regarding their rights and obligations in the QUEST program.
74	40.315	116	1st paragraph	The plan must make an effort to notify QUEST-Net and QUEST-ACE members prior to providing service for a non-covered benefit, or if they are exceeding coverage limits. Will a notice in the member handbook regarding coverage and benefits be considered sufficient notice?	See response to question 73.
75	40.325	119	1st paragraph	Can plans utilize written and/or phone surveys as a method to identify individuals with Special Health Care Needs?	Written and/or phone surveys may be used as part of a strategy to identify individuals with Special Health Care Needs but they are not to be the only method of identifying these individuals.

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# Assigned	Section	Page #	Para.	Question	Response
76	40.330	122	1	Obesity management has been selected as a disease management program topic a health plan can select to implement. In Appendix O, # 7, excluded services include obesity treatment, weight loss programs; food, food supplements including prepared formulas, health foods. Does this mean these or like services cannot be incorporated into an obesity disease management program developed by a health plan?	This question lacks the clarity necessary to respond in a comprehensive fashion. Some weight loss and obesity treatment programs could be included and provided as covered services. However, gym memberships or commercially sponsored weight loss programs could not be included. A health plan may provide services which are not included in the capitation payment should they choose to do so.
77	40.340	127	Bullet 1	This section states the health plan is financially responsible for post-stabilization services if the health plan does not respond to the provider's request for pre-certification or prior authorization within one hour. This conflicts with Section 50.700, page 200, bullet 1. Please clarify.	These sections are not in conflict with one another. Section 40.340 refers to payment for post-stabilization services while Section 50.700 refers to authorization and pre-certification activities.
78	40.355	130	1	If a member seeks family planning services from an out-of-network provider, is the health plan responsible for covering the service if the health plan has a sufficient number of in-network family planning providers?	Yes, the health plan is responsible for covering family planning services from an out-of-network provider if the health plan has a sufficient number of in-network family planning providers.
79	40.355	130	1st	For family planning services, RFP states that member freedom of choice may not be restricted to in-network providers. If the provider is not part of the plan's network, is there any fee established that the provider must accept as payment in full? Will DHS establish in-network and out-of-network fee schedule by provider-type (e.g., physician, advanced practice nurse)?	The State will not establish fee schedules for the health plans. However, the State has established fee schedules for services provided under the Medicaid fee-for service program which the health plan may use as a baseline.

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# Assigned	Section	Page #	Para.	Question	Response
80	40.355	130	1st	For family planning services, RFP states that member freedom of choice may not be restricted to in-network provider. Since non-network providers will not be credentialed or contracted, are the health plans excused from the responsibility from other RFP requirements with respect to these providers such as ensuring access to records, appointment availability standards, medical record keeping practices, ADA requirements, etc. (items we address either through our credentialing or contracting processes)?	The health plan is still required to make sure that the provider meets minimum qualifications in order to reimburse the provider for services.
81	40.355	130	2nd bullet	Under Family Planning Services, emergency contraception is included in the minimum services for which Plans are responsible. Does this requirement also include plan coverage for patient counseling by pharmacists for emergency contraception? How will this additional requirement in the new RFP be factored into the proposed capitation rate and will the bidders be able to see utilization and unit cost data and discuss the assumptions with the actuaries?	Such counseling is an additional service that only specially trained pharmacists can provide. It is included in the capitation rate.
82	40.355	130	1st paragraph	Are Plans required to pay for services if members choose to go out of network?	Yes, if the services are family planning services.
83	40.360	133	2nd paragraph	Please clarify the QUEST-Net and QUEST-ACE benefit as it relates to ITOPs. It is not clear that it is NOT covered.	The health plan is not responsible for providing ITOPs to any beneficiaries.

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# Assigned	Section	Page #	Para.	Question	Response
84	40.360	133	2	RFP states: "The health plan is not responsible for covering ITOPs or related services performed for family planning purposes." Who do the health plans direct the providers to for payment of ITOPs for family planning purposes? If the ITOP is not performed for family planning purposes, but for health of the mother, serious problem found in genetic testing, etc. – who is responsible for covering the ITOP?	See # 9 of Amendment #9. The State will pay for all ITOPs.
85	40.365	133	1st paragraph	RFP states: "The health plan shall inform its providers in writing, at least thirty (30) days in advance of any drugs deleted from its formulary." When a generic equivalent is added to the health plan formulary, can the health plan remove the brand from the formulary without notification to the providers since the same drug/chemical remains on the formulary? Note: State law requires pharmacists to dispense an A-rated generic when available with the exception of drugs to treat epilepsy.	No. However, the DHS recommends that prescribers and pharmacies in a health plan's network understand that the plan will not notify them for multisource A-rated generics.
86	40.370	135	1	If a benefit year is defined as the period between July 1 through June 30, how will a benefit year be applied if this contract begins February 2007?	The benefit year will be pro-rated. Benefit limits will be 5/12th of the full year limits.
87	40.370	136	Last sentence on page	The RFP reads "The health plan may develop its own payment methodologies for Methadone/ LAAM Services". Does this mean the plans no longer have to follow the previously prescribed criteria by the state: paying for monitoring services at $10.00 Methadone and $5.50 per daily dose?	Correct, plans no longer have to follow the previously prescribed criteria.

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# Assigned	Section	Page #	Para.	Question	Response
88	40.370	136	1st	If methadone or LAAM services are only available in certain geographic locations (Oahu, Hilo), can the plans offer more traditional substance abuse services to the member i.e.: IOP, LIOP, instead of this modality of care?	The health plan is required to provide all services that are medically necessary for a member, including but not limited to methadone or LAAM services, regardless of their availability on the island of the member's residence. The health plan may also provide more traditional substance abuse services but if the member requires methadone or LAAM services, the health pan is responsible for ensuring the member is able to access these services, even it this requires transporting the member to another island to obtain the service.
89	40.370	137	3rd bullet	The RFP reads "the plan is not responsible for providing BH services to adult members who have been determined for and transferred to BHMC." Does this include ER visits for psychiatric problems, physicals for admission to residential and inpatient admissions, BH medications, labs for drug screens or lithium levels etc, hospital facility charges for ECT? Additionally, what is the expectation for Case Management if a member is in BHMC? Is the plan relieved of the SHCN requirements for this member as it relates to BH?	Once a member is enrolled in the BHMC, the health plan is not responsible for ER visits for which the diagnosis is a behavioral health one, BH medications or other specific behavioral health services. The health plan is responsible for case management of all physical/medical health services as medically necessary. No, the health plan is not relieved of the SHCN requirements for this member as it relates to behavioral health.

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# Assigned	Section	Page #	Para.	Question	Response
90	40.370	137	4th bullet	The RFP reads "the health plan is not obligated for those criminally committed for evaluation or treatment in an inpatient setting under provisions of chapter 706 HRS". These individuals will be the clinical and financial responsibility of the appropriate state agency." If a plan member is under Case Management at the time he/she is criminally committed, is there an expectation for the HP to coordinate care or pass on case management information to the appropriate state agency that has responsibility for the member? If yes, could you describe the referral process and provide information on contact persons/departments within the appropriate state agencies?	Yes. The health plan is required to coordinate the care and the transition of the members to the appropriate State agency. The plan is required to abide by all state and federal laws regarding the release of information. Specific information about the referral process and contact persons/ departments will be provided to offerors awarded contracts.
91	40.380	140	1	The health plan shall require that all providers participating in a health plan utilize the standard EPSDT screening form prescribed by the DHS. Is this form Appendix P? If not, could you please provide the form? If a provider currently does not utilize the prescribed DHS form, can the provider continue to utilize a similar form in his/her practice if it contains the same elements and captures the same information?	Appendix P is not the standard format; the format will be provided to Offerors who are awarded a contract. The provider can not continue to utilize a similar form.
92	40.380	140	1st paragraph	Is the "standard EPSDT screening form" that providers must utilize the same as the guidelines in Appendix P?	See answer to question 91.
93	40.380	140	3	Will DHS continue to provide health plans with copies of "Mikah the Myna Bird" flyer to distribute to EPSDT eligible members?	Yes.

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# Assigned	Section	Page #	Para.	Question	Response
94	40.380	142	Bullets 2 & 3	Is the standard EPSDT screening tool that same form that providers would be required to use for interperiodic screening services? If the provider does not currently utilize this form but uses a similar form, would that suffice?	See answer to question 91.
95	40.380	142	Bullet 2	Please describe what components are included in a partial screen? Can partial screens be counted in the CMS 416 report?	A partial screen is any screen that does not include all components in Appendix P. No, partial screens can not be counted on the CMS 416 report.
96	40.380	143	2, last sentence and bullets	For children in the SEBD program, a family may elect that the health plan shall provide therapeutic services instead of DOE/DOH for medically necessary outpatient BH services. Are the bullet items following the paragraph the therapeutic services that the Plan may be responsible for if the family opts to use Plan benefits instead of DOE/DOH? Or are these bulleted items exclusively the responsibility of DOE/DOH?	The bullet items following the paragraph are services that are exclusively the responsibility of DOE/DOH.

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# Assigned	Section	Page #	Para.	Question	Response
97	40.380	143	Last	The RFP reads "in the event the family selects this option the health plan shall provide said therapeutic services." If the "said therapeutic services" refer to the bulleted items listed after the paragraph, could you please provide the following information? 1. Crisis Residential Services- Will you provide a list of where these services can be obtained? Why would this not paid be by DOE since it is a residential bed? 2. Biopsychosocial Rehab Program – Level 1 - Please provide a description of this service and the criteria, as well as list of providers who offer it? Why would this not be paid by DOE since it is their criteria and definition? 3. Biopsychosocial Rehab Program – Level 2 – Will you provide a description of this service and the criteria, as well as list of providers who offer it? Why would this not be paid by DOE since it is their criteria and level definition? 4. Therapeutic Living Support - Will you provide a description of this service and the criteria, as well as a list of providers who offer it? Why would this not be paid by DOE? 5. Therapeutic Foster Supports - Will you provide a description of this service and the criteria, as well as a list of providers who offer it? Why would this not be paid by DOE? 6. Hospital-based Residential Services - Residential Service was previously not a covered QUEST benefit. Is this still the case? Why would this not be paid by DOE? 7. How will the proposed capitation rate be expanded in this RFP to account for benefit expansion, since these services used to be paid by CCS under the SED criteria?	The said therapeutic services do not refer to the bulleted items listed after the paragraph. The bulleted items are services for which the State is responsible.

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# Assigned	Section	Page #	Para.	Question	Response
98	40.380	143	2	The RFP states the "health plan is responsible for coordinating services with the DOE and DOH". In the past, members have had to wait anywhere 2-3 months to obtain an evaluation to access DOE/ DOH services. If a plan member is referred to the DOE/DOH for an evaluation, what is the expected response time from these agencies to perform the evaluation? Could you clearly describe the referral process to DOE and SEBD?	There is no standard response time as it is dependent upon workload and resource allocation in both the DOE and the DOH. A QUEST Memo (ADM-0305) was issued that provided instructions for direct referral by a health plan to CAMHD along with the criteria to expedite referral.
99	40.380	143	2	In the event a member determined SEBD decides to receive outpatient behavioral health services required for the educational needs from the health plan rather than DOE or DOH, will the health plan be reimbursed by DHS for providing said therapeutic services?	Yes
100	40.400	147	Bullet 7	Not including the requirement of the 8th bullet (share SCHN assessment findings) and MQD expectations that information relating to prior authorized services will be shared during the transition period for existing members, could you please provide details on the minimum level of coordination of care expected between health plans?	There is no defined "minimum level of care coordination" as it is dependent on the individual needs of members. The goal is to ensure that services are coordinated, not duplicated and provided in an appropriate manner in order to ensure quality of care to all members.
101	40.400	147	Bullet 8	To comply with HIPAA, a signed release from the member is needed. Can this section be amended to add with a signed release from the member?	See response to question 22. No, this section will not be amended.
102	40.500	148	4	If a second opinion can be arranged through an in-network provider, under what condition(s) is a health plan required to provide a second opinion from an out-of-network provider?	The health plan is required to provide a second opinion. If one is available through an in-network provider the health plan does not have to provide one through an out-of-network provider.

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# Assigned	Section	Page #	Para.	Question	Response
103	40.600	149	2	How will the "new" health plan know what prior authorizations were approved by the member's "old" health plan while still complying with HIPAA? If it will be through a member release, then can this section be amended to add with a signed release from the member?	See response to question 22. No, this section will not be amended.
104	40.800	151	2nd paragraph	"When the individual requests the health plan to provide the services as opposed to DOE or DOH, in these circumstances, the health plan shall follow the procedures in Section 30.770. The DHS will reimburse the health plan for these services." What procedures are meant? The referenced Section 30.770 just says the Child & Adolescent Mental Health Division will provide the services and the children will be considered to have special health care needs.	See # 10 of Amendment #9.
105	40.800	151	2nd paragraph	How will the Plans be reimbursed for providing these services?	See response to question #104.
106	40.810	153	1	The RFP states "if denied eligibility to SEBD services by CAMHD, CAMHD must provide written denial and notification of appeal rights." Will CAMHD reimburse the plans for care rendered during the appeal if the appeal is overturned? Additionally, will CAMHD be providing a listing of members who will be disenrolled 30 days in advance of disenrollment so that plans can coordinate care?	CAMHD will be responsible to provide and pay for services during the appeal process so there should not be a need for CAMHD to reimburse the plan for services. CAMHD and the plan should be coordinating care to allow coordination of care and a transition plan should be developed ahead of time should the recipient be disenrolled from CAMHD.
107	40.820	153	Enrollment in BHMC	Will the State be able to provide a turnaround time standard for plans with regards to the BHMC review process?	No, there is no standard turnaround time as it is dependent upon workload and resource allocation.

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# Assigned	Section	Page #	Para.	Question	Response
108	40.820	153-154	Last	The RFP reads "Upon determination by DHS that a member no longer meets the criteria for enrollment in the BHMC plan, DHS will disenroll the member and notify the health plan." Will the state allow an appeal of eligibility to BHMC and if so, please share the process and forms. Also, will the state provide us ample notice of disenrollment (i.e.: 30 days) to facilitate timely coordination of care with the BHMC?	The member is allowed to appeal an eligibility determination through the State's administrative hearing process. There are no particular forms. The State will work with the health plans to ensure coordination of care.
109	40.900	155	2nd paragraph	Appears to say that the plan pays return transportation to Hawaii for members who require care while out of state, if the plan has paid for their care. That would seem to include, for example, those who become ill or injured and receive covered care while visiting or studying out of state. Is this the intent? If not, will the language of this section be changed and perhaps coordinated with Section 41.120?	See # 12 of Amendment #9. The health plan is responsible for providing emergency services to members who are out-of-state for any reason. Transportation shall be provided upon discharge from an out-of-state facility provided the member received emergency or post-stabilization services or the service was prior authorized.
110	41.120	157	1	Can a health plan require that an attendant be 18 years or older and capable of assisting the member?	Yes.
111	41.120	157	2	If a health plan makes arrangements to transport providers, can the transportation cost be reported as a benefit expense?	Yes
112	41.140	158	1st and bullets	Please clarify. Is the health plan responsible for re-evaluations for certification of physical or mental impairment for members in TANF while DHS is responsible for members in the General Assistance aid category?	See # 13 of amendment #9

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# Assigned	Section	Page #	Para.	Question	Response
113	41.140	158	Last	For Certification of Physical or Mental Impairment, plans must use the panel of providers provided by the DHS. If the provider is not part of the plan's network, is there any fee established that the provider must accept as payment in full?	No, there is no fee established.
114	41.140	158	3	Can DHS provide a listing of its panel of providers used for mental disability evaluations?	Prior to February 1, 2007, a listing will be provided to offerors who receive a contract.
115	41.150	159	Foster Care/ CWS…	Are all CWS cases under the foster care system? Conversely, are all foster care members under the CWS system? If not, under what circumstances would they not? For the purpose of plan identification of CWS children, is it safe to assume that only children who are enrolled under the foster care rate codes would be subject to the foster care/CWS requirements? How can DHS foster/ facilitate cooperation between the HP and CWS?	No, all CWS cases are not under the foster care system. Yes, all foster care members are under the CWS system. Yes, only children enrolled under the foster care rate codes would be subject to the foster care/CWS requirements. The State will continue to work with all partners to facilitate cooperation and ensure that members receive appropriate and necessary care in the most appropriate setting.
116	41.150	159	1	Does this section give CWS workers the ability to seek physical examinations outside of a health plan's network without consultation from the health plan?	Yes, the section does give CWS workers the ability to seek physical examinations outside the network.
117	41.150	159	1st paragraph	How will plans be notified of children taken into custody who need the 45 day placement exam? Will the Plan be responsible for exams when the case worker does not utilize the Plan's provider network?	The CWS workers will contact the health plan's foster care coordinator. Yes, the plan will be responsible for exams when the case worker does not utilize the Plan's provider network.

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# Assigned	Section	Page #	Para.	Question	Response
118	41.200	160	2	If a member moves in the middle of the month to a different island that a health plan is not on, will the health plan remain responsible for the care and the cost of the services provided to the member for the remainder of the month? If yes, because eligibility is daily, can the member change occur on the date the member notifies Med-QUEST?	Yes, the health plan will remain responsible for the care and cost of the services provided for the remainder of the month. All enrollments and disenrollments will occur once per month; there will be no daily changes.
119	41.200	160	3	How will the "new" health plan know what prior authorizations were approved by the member's "old" health plan while still complying with HIPAA? If it will be through a member release, then can this section be amended to add with a signed release from the member?	See answer to question 22.
120	50.100	161		Are plans required to include their provider listing in the member enrollment packet?	No. The health plans shall provide the provider directory to the State who will provide this to the enrollee at the time of enrollment processing in order for enrollees to best make a health plan selection.

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# Assigned	Section	Page #	Para.	Question	Response
121	50.100	161	2nd paragraph	"Upon receipt of enrollment information from the DHS, the health plan shall issue a new member enrollment packet within ten (10) days of enrollment by DHS." Please clarify when the plan is expected to issue a new member enrollment packet. The date the plan receives enrollment information from DHS is usually not the same date that the member is enrolled by DHS.	See #14, #15, and #16 of Amendment #9.
122	50.100	162	Last bullet	Clarify when the plan must issue the member ID card. Section 50.100 states the plan shall issue a new member enrollment packet (including a membership card) within 10 days of enrollment by DHS. Section 50.360, page 181, states the plan shall mail a member ID card within 10 days of member selecting a PCP or being auto-assigned a PCP.	See answer to question 121.

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# Assigned	Section	Page #	Para.	Question	Response
123	50.100 50.120 50.630	161-163 181	2nd Paragraph, last bullet; 1st bullet; 1st bullet and 4th bullet	As described in the last bullet in Section 50.100 the Plan must, within 10 days of enrollment, send each enrollee a Member ID Card as part of the Enrollment packet. This bullet directs the reader to Section 50.360 that states the PCP name and phone number must be on the Member ID Card. Section 50.120 states the Plan must give the member 10 days to choose a PCP before one can be auto-assigned by the Plan. The concern is, if the Enrollment Packet has to include the ID Card and the ID Card has to include the PCP name and number, the Plan can not meet the mailing timeline of 10 days if we must to allow 10 days for the member to pick a the PCP. Would DHS consider one of the following: (1) Give the plan additional time to mail the enrollment packet (2) cut down the timeframe members have to choose their PCP (3) allow the plan to mail the Member ID Card separately either after the member has chosen their PCP or the plan has made the auto-assignment?	See answer to question 121.
124	50.110	162	2nd paragraph	For an attendant (if applicable), is plan only responsible for meals & lodging?	No. As stated in Section 50.110 and 40.900 the health plan is also responsible for transportation costs for the attendant.

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# Assigned	Section	Page #	Para.	Question	Response
125	50.110	163	2nd paragraph	This states that when a member changes from FFS to QUEST during a hospital stay, that the new health plan will be responsible for professional fees and outpatient prescription drugs from the date of enrollment into the health plan. Does this also apply when the member changes from QUEST to FFS?	See #17 of amendment #9.
126	50.130	164	1	Besides filing 1179s for member information change, there is a requirement for the plan to notify the member that he or she is also responsible for providing the information to DHS. Will DHS make updates to the system based on the 1179, particularly in cases where member cannot be contacted (example: plan receives verification of TPL termination but cannot contact member).	Yes, EB EW updates information reported on the DHS 1179 in the department's HAWI system.
127	50.140	165	Enrollment for Newborns	The health plan shall notify the DHS within 24 hours of receiving notification of the birth of a newborn to a member. If the notification to the health plan is received on a weekend (i.e., Saturday), will notification on the first business day following the weekend (i.e., Monday) meet this requirement?	See #18 of amendment #9.
128	50.150	165	1	RFP states: "The health plan shall assist the DHS in meeting all citizen documentation requirements prescribed in Section 6037 of the DRA." Could you please provide details on the specific assistance MQD sees as the role of a health plan in this regard?	Med-QUEST sees the health plan as a partner in meeting citizenship, alien status and identification documentation requirements in order to ensure that members receive appropriate and necessary services and to ensure that the State and the health plans continue to receive federal matching funds.

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# Assigned	Section	Page #	Para.	Question	Response
129	50.150	165	1st paragraph	What is the Plan expected to do to assist the DHS in meeting all citizen documentation requirements?	See response to question 128.
130	50.210	166		Why was "Medicare eligible member who chooses FFS" removed from the list of reasons a plan can request disenrollment?	This was removed because this is not a reason a plan can request disenrollment, though it is a reason a member may request disenrollment. .
131	50.220	167	2nd paragraph	BBA language states that the member's disenrollment will become effective no later than the first day of the second month from the month in which the enrollee or the Plan **files the request** (not from when the determination was made). This suspected error can be found in other sections throughout the RFP.	See #19 of amendment #9.
132	50.230	168	"Aid to Disabled... "	For a member newly assigned to a HP, would the State be willing to perform an expedited review if the member's previous health plan failed to submit the member for an ADRC referral? If the member is accepted after the ADRC review process, would the State also consider retro-enrolling the member into the FFS program from the date of enrollment into the new HP if the member clearly met the ADRC criteria prior to the HP change?	No to both.
133	50.230	168	Bullet 2	Where can health plans get copies of form DHS 1156 - Physical Examination Report, DHS 1271 - Report of Evaluation, DHS 1150 - Patient Assessment for ICF-MR Services Prior Authorization?	The Forms Manual is part of the Documentation Library and can be found there.
134	50.230	168	1st	How long does it take to receive an appointment with the Aid to Disabled Review Committee (ADRC) for an evaluation?	The section refers to written referrals to the ADRC and not appointments. Refer to #20 of Amendment #9.

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# Assigned	Section	Page #	Para.	Question	Response
135	50.230	168	2nd bullet	Are plans required to use all the forms listed (if applicable)? Will ADRCs submitted without these forms prior to contract effective date be valid?	Yes, plans are required to use all the forms listed. ADRC determinations submitted prior to the contract date which have not been acted upon will be accepted but MQD reserves the right to request additional information not submitted which may delay the decision.
136	50.230	169	1	What is the timeframe a health plan can expect an ADRC determination from DHS once all the necessary documents are submitted? What is the expected turnaround time to disenroll a member once the determination decision is made? Will the date of disenrollment go back to the date of the ADRC determination?	See response to question 48. No, the date of disenrollment will not go back to the date of the ADRC determination.
137	50.250	171	Last bullet	This bullet states that there may be specific instances when uncooperative or disruptive member behaviors may result in DHS disenrolling the member from the Plan. Could you provide some detailed examples and also describe the notification and decision-making process and timelines should there be an instance that may warrant consideration for health plan disenrollment.	No, the State will not provide detailed examples as it will be determined on a case-by-case basis. The plan shall submit their request to MQD including the reason and justification.
138	50.320	173	1st paragraph	"The health plan shall use easily understood language and formats for **all** written materials." Is this requirement for all member-related written materials?	Yes.